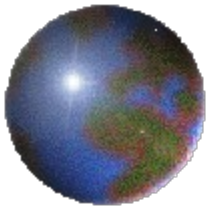

Medical Documentation and Coding 1995 Guidelines

Carnell Hansley, BS, RHIT

August 2003

Outline

- The Importance of Documentation
- What Payer's Want
- Principles of Medical Record Documentation
- Documentation of E/M Services
- Components for Level of E/M
- Key Components

August 14, CMS 1995 Guidel

Outline cont'd

- History
- Elements of Required History
- Specific Documentation Guidelines
- Past, Family and/or Social History (PFSH)
- Documentation of Examination

August 14, CMS 1995 Guidel

Outline cont'd

- Documenting Complexity of Medical Decision-Making of Data to be Reviewed
- Number of Diagnoses or Management Options
- Amount and/or Complexity of Data to be Reviewed
- Risk of Significant Complexity of Data to be Reviewed
- Documentation of an Encounter Dominated by Counseling or Coordination of Care

August 14, CMS 1995 Guidel

The Importance of Documentation

- Medical record documentation is required to:
  - Record pertinent facts, findings, and observations about an individuals health history
- An individual's health history may consists of:
  - Past and present illnesses, examinations, tests, treatments, and outcomes

August 14, CMS 1995 Guidel

The Importance of Documentation cont'd

- The medical record chronologically documents the care of the patient and is an important element which contributes to high quality care.

- The medical record facilitates:

  - Ability to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time

August 14, CMS 1995 Guidel

The Importance of Documentation cont'd

- Communication and continuity of care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data useful for research and education

August 14, CMS 1995 Guidel

The Importance of Documentation cont'd

- An appropriately documented medical record can:

- Reduce the hassle associated with claims processing

- Serve as a legal document to verify care provided

August 14, CMS 1995 Guidel

What Payers Want

- Payers have a contractual obligation to enrollees thus they require reasonable documentation to show that the services rendered are consistent with the insurance coverage provided.

- Valid information of services rendered:
  - Site of service
  - Medical necessity and appropriateness of the diagnostic and/or therapeutic services provided
  - Services provided accurately reported

August 14, CMS 1995 Guidel

Principals of Medical Record Documentation

- Principles applicable to all types of medical and surgical services in all settings.

- For Evaluation and Management (E&M) services the nature and amount of physician work and documentation varies by:

  - Type of service
  - Place of service
  - Patient's status

Principles cont'd

- The medical record should be complete and legible
- Documentation of each patient encounter should include:
- Reason for encounter
  - Relevant history
  - Physical examination findings and prior diagnostic tests results

Principles cont'd

- Assessment, clinical impression or diagnosis
- Plan of care
- Date and legible identity of the observer

- In the absence of documentation, the rationale for ordering diagnostic and other ancillary services should easily inferred

- Past and present diagnoses accessible to the treating and/or consulting physician

Principles cont'd

- Identification of appropriate health risk factors
- Documentation of the patient's progress, response to changes in treatment, and revision of diagnosis
- Documentation to support CPT and ICD-9-CM codes should be reported on the health insurance claim form or billing statement

August 14, CMS 1995 Guidel

Documentation of E/M Services

- E/M services and visits for counseling and coordination of care

- Three key components:
  - History
  - Examination
  - Medical decision-making

August 14, CMS 1995 Guidel

Documentation of E/M Services cont'd

- Used for the following services:
  - Consultations
  - Home services
  - Office and other Outpatient services
  - Hospital observation services

Documentation of E/M Services cont'd

- Hospital inpatient services
- Emergency department services
- Hospital observation services
- Nursing facility services
- Domiciliary care services

August 14, CMS 1995 Guidel

Components for Level of E/M

- History
- Examination
- Medical decision-making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

August 14, 2003 CMS 1995 Guidel

Key Components

- History
- Examination
- Medical decision-making
- ***exception to this rule are visits which consists primarily of counseling or coordination of care; in these instances time is the key factor for determining a specific level of E/M service.***

August 14, CMS 1995 Guidel

History

- Level of service is based on four types of history:
- Problem focused
- Expanded
- Detailed
- Comprehensive

August 14, CMS 1995 Guidel

Elements Required for Histories

History of Present Illness (HPI)	Review of System (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	***Problem Focused***
Brief	Problem Pertinent	N/A	***Expanded Problem Focused***
Extended	Extended	Pertinent	***Detailed***
Extended	Complete	Complete	***Comprehensive***

Specific Documentation Guidelines

- Chief Complaint (CC) - concise statement describing the:
  - Symptom Problem
  - Condition Diagnosis
  - Physician recommended other factor that is the return reason for the encounter

Specific Documentation Guidelines cont'd

- History of the present illness (HPI) – chronological description of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.

- Included in the assessment:

  - Location Quality
  - Severity Duration
  - Timing Context
  - Modifying factors Associated signs and symptoms

Specific Documentation Guidelines cont'd

- Review of Systems (ROS):

- Inventory of body systems obtained through a series of questions seeking to identify:

  - signs and/or symptoms the patient may be experiencing or has experienced.

Specific Documentation Guidelines cont'd

- For purposes of ROS, the following systems are recognized:
  - Constitutional symptoms (e.g., fever, weight loss)
  - Eyes
  - Ears, Nose, Mouth, Throat

Specific Documentation Guidelines cont'd

- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integument (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergic/Immunologic

Past, Family and/or Social History (PFSH)

- The PFSH consists of a review of three areas:
  - Past history (the patient's past experiences with illnesses, operations, injuries and treatments
  - family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)

Past, Family and/or Social History (PFSH)

- social history (an age appropriate review of past and current activities).

- CPT requires only an “interval” history for categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care. In these instances it is not necessary to record information about the PFSH.

Documentation of Examination

- E/M levels of service are based on four types of examinations as follows:
  - ***Problem Focused*** -- a limited examination of the affected body area or organ system.
  - ***Expanded Problem Focused*** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Documentation of Examination cont'd

- ***Detailed*** – an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

- ***Comprehensive*** -- a general multi-system examination or complete examination of a single organ system.

- The following ***body areas*** are recognized for purposes of examination:

  - Head, including the face

Documentation of Examination cont'd

- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

- For purposes of examination, the following ***organ systems*** are recognized:
  - Constitutional (e.g., vital signs, general appearance)
  - Eyes

Documentation of Examination cont'd

- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Documenting Complexity of Medical Decision-Making

- Four levels of E/M services involved with medical decision making; straight-forward,low complexity, moderate complexity and high complexity

- Medical decision is the complexity of establishing a diagnosis and/or selecting a management option as measured by:

  - the number of possible diagnoses and/or the number of management options that must be considered

Documenting Complexity of Medical Decision-Making

- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed

- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

August 14, CMS 1995 Guidel

Documenting Complexity of Medical Decision-Making

Number of diagnosis or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision-making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Moderate	High	***High Complexity***

August 14, CMS 1995 Guidel

Number of Diagnoses or Management Options

- Number of possible diagnoses and/or the number of management options to consider is based on the number and type of problems addressed during the encounter
- The complexity of establishing a diagnosis
- The management decisions that are made by the physician.
- The decision making process is generally easier with a diagnosed problem than that for an identified but undiagnosed problem.

Number of Diagnoses or Management Options cont'd

- The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses.

- Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected.

- The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

August 14, CMS 1995 Guidel

Amount and/or Complexity of Data to be Reviewed

- Amount and complexity of data to be reviewed based on the type of diagnostic testing ordered or reviewed.

- Decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Amount and/or Complexity of Data to be Reviewed cont'd

- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed.

- On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

Risk of Significant Complications, Morbidity, and/or Mortality

- The risk of significant complications, morbidity, and/or mortality is based on the risks associated with:
  - The presenting problem(s)
  - The diagnostic procedure(s)
  - The possible management options.

Documentation of an Encounter Dominated by Counseling or Coordination of Care

- In cases where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility):
  - time is considered the key or controlling factor to qualify for a particular level of E/M services.

August 14, CMS 1995 Guidel